Administered by:

Blue Cross and Blue Shield of New Mexico

Los Alamos National Labs

Plan Highlights – Active EE/Retiree w/out Medicare

Active EE/Retiree HDHP Medical Program Cost-Sharing Features, Covered Services, and Limitations	Member's Share of Covered Charges	
	Preferred Provider (In-Network)[1,2]	Nonpreferred Provider (Out-of-Network)[1,2]
Calendar Year Deductible[1] (Family deductible is an aggregate of two times individual amount.) No individual deductible under family coverage.	$1,500 Individual $3,000 Family	$3,000 Individual $6,000 Family
Calendar Year Out-of-Pocket Limit[2] (Includes deductible, copayments, and percentage coinsurance amounts. Family limit is an aggregate of two times individual amount.) No individual out-of-pocket under family coverage.	$3,000 Individual $6,000 Family	$6,000 Individual $12,000 Family
Lifetime Maximum Benefit Limit (per member)	Unlimited	Unlimited
Office Visit/Exam Charge	10% after deductible	40% after deductible
Allergy Injections	10% after deductible	40% after deductible
Allergy Care (such as allergy testing; extract preparation)	10% after deductible	40% after deductible
Therapeutic Injections: Office Surgery and Supplies	10% after deductible[4]	40% after deductible[4]
Lab, X-Ray, and Other diagnostic Tests (Nonroutine/nonpreventive)	10% after deductible[4]	40% after deductible[4]
Nutritional Counseling (**3 sessions/lifetime** for certain conditions)	10% after deductible	40% after deductible
PREVENTIVE SERVICES		
Routine/Preventive Well-Baby Care (Through Age 2): Including check-ups, routine screening; routine laboratory tests; immunizations	No Charge	40% (deductible waived)
Routine/Preventive Adult Care (Ages 3 and Older): Including routine physicals, gynecological exams; well-child care, vision/hearing screenings, routine mammograms, routine colonoscopies, immunizations, pap tests, cholesterol tests, urinalysis, etc.	No Charge	40% after deductible
Family Planning (including devices, insertion, Depo-Provera, etc.)	No Charge	40% after deductible
OTHER MEDICAL/SURGICAL SERVICES		
Acupuncture Treatment (limited to **20 visits**/year)	10% after deductible	40% after deductible
Ambulance: Emergency Transport (Ground and Emergency Air, as needed)	10% after In-Network deductible[3]	
Ambulance: NonEmergency Ground Transport (between facilities)	10% after In-Network deductible[4]	
Ambulance: Nonemergency Air Transfer (between facilities)	10% after deductible[4]	40% after deductible[4]
Emergency Room Visit (*emergency* condition only; including facility, Physician and Other Professional Provider Charges)	10% after In-Network deductible[3]	
Cancer/Congenital Heart Disease Care (Blue distinction programs only include a lodging per diem benefit of **$50** per person, or **$100**/day for 2-3 persons. Travel and the above per diem allowances combined are limited to **$10,000** per lifetime for each program utilized. If program is not used, benefits are same as for any other service, per place of treatment, provider contract and type of service.)	10% after deductible[4,5]	40% after deductible[4,5]
Cardiac & Pulmonary Rehabilitation, Outpatient/Office	10% after deductible	40% after deductible[4]
Dental/Facial Accident[3], Oral Surgery, and TMJ/CMJ Services (for limited, non-dental medical conditions; see a benefits booklet for details)	10% after deductible[4]	40% after deductible[4]
Hearing-Related Services for members 21 years and younger: -Office exams and evaluations: cochlear implant; auditory testing -Hearing aid services (maximum total benefit of **two hearing aids every 3-years**, including fitting of hearing aid and ear molds)	10% after deductible	40% after deductible
Hearing-Related Services for members 22 years and older: -Office exams and evaluations: cochlear implant; auditory testing -Hearing aid services (maximum total benefit of **$2,200** during **36-month period**, including fitting of hearing aid and ear molds)	10% after deductible	40% after deductible

Active EE/Retiree HDHP Medical Program Cost-Sharing Features, Covered Services, and Limitations	Member's Share of Covered Charges	
	Preferred Provider (In-Network)[1,2]	Nonpreferred Provider (Out-of-Network)[1,2]
Home Health Care/Home I.V. Services (Private duty nursing **not** covered; care must be from a licensed home health care agency): Home Health care agency services and home I.V. services (Out-of-network limited to **100 visits**/calendar year)	10% after deductible[4]	40% after deductible[4]
Hospice Services including bereavement counseling when such services are provided by hospice (Respite care limited to **10 days** for each 6-month benefit period)	10% after deductible[4]	40% after deductible[4]
Hospital/Other Facility: Inpatient		
-**Medical/Surgical Acute Care, Observation, Medical Detox,** and **Extended Stay (Nonroutine) for Covered Newborn**: Room/Board, and Covered Ancillaries -**Maternity Hospital Fees and Birthing Center** **-Skilled Nursing Facility** and Inpatient **Physical Rehabilitation** (max. **100 days** per calendar year for preferred and nonpreferred combined; in addition, nonpreferred services cannot exceed **70 days** per calendar year) -Inpatient **Physician's Medical visit** or **Consultation;** **-**Inpatient **Surgeon, Anesthesiologist, Radiologist, Pathologist,** and **Assistant Surgeon**	10% after deductible[5]	40% after deductible[5]
Hospital/Other Facility: Outpatient/Ambulatory Surgery Center (includes covered services, whether billed by facility or professional provider, including surgery, diagnostic test, chemotherapy, dialysis, and radiation treatment.)	10% after deductible[4]	40% after deductible[4]
Lab, X-ray, and Other Diagnostic Tests (nonpreventive) Including MRI, CT Scans, and PET Scans; Sleep Studies; EKGs, etc. –Office or Freestanding/Independent Facility or Outpatient Hospital	10% after deductible[4]	40% after deductible[4]
Maternity Care -Initial visit to confirm pregnancy -All other expenses	10% after deductible 10% after deductible[5]	40% after deductible 40% after deductible[5]
Short-Term Rehabilitation; Outpatient and Office (Includes Physical, Occupational, and Speech therapy services, each are limited to **20 visits**/calendar year. Speech therapy is limited to specified medical conditions; see a benefit booklet for details.)	10% after deductible[4]	40% after deductible[4]
Spinal/Osteopathic Manipulation/Naprapathy (limited to **20 visits**/calendar year combined)	10% after deductible	40% after deductible
Supplies, Durable Medical Equipment, Prosthetics, Orthotics (Includes insulin pumps and pump supplies; support hose limited to **6 pair**/year; mastectomy bras limited to **3/year**; For diabetic supplies such as needles, test strips, glucagon, etc., see drug plan provision)	10% after deductible[4,6]	40% after deductible[4,6]
Therapy: Chemotherapy, Dialysis, and Radiation	10% after deductible[4]	40% after deductible[4]
Transplant Services: Limitations apply to donor charges and travel and lodging. Must be received at a facility that contracts with BCBSNM or with the national BCBS transplant network.	10% after deductible[4,5]	Not Covered Out-of-Network
Travel and Lodging: Benefits are available when these services are related to case-managed Cancer Services or Congenital Heart Disease if patient is receiving treatment from a Blue Distinction Center for Specialty Care or case-managed transplants (excluding cornea). Travel for more than 50 miles must be necessary in order to be eligible for coverage under this provision. For each of the three benefit programs, the benefits are as follows: `		
-Travel to and from health care facility plus per diem payments listed below -Lodging per diem for patient and/or companion(s)	$10,000/lifetime after In-Network deductible[4] $50/Individual or $100 for 2-3 persons after In-Network deductible[4]	
-Ancillary Services (lab, x-rays, supplies, etc.)	10% after deductible	40% after deductible
Urgent Care Facility	10% after deductible	40% after deductible
BEHAVIORAL HEALTH: Mental Health and Chemical Dependency		
Mental Health Services -Office, Outpatient, Intensive Outpatient Programs (IOP); Inpatient and/or Partial Hospitalization	10% after deductible[4,5]	40% after deductible[4,5]
Chemical Dependency Rehabilitation -Office, Outpatient, Intensive Outpatient Programs (IOP), Outpatient Suboxone; Inpatient and/or Partial Hospitalization	10% after deductible[4,5]	40% after deductible[4,5]
-Residential Treatment Center for Chemical Dependency and Mental Health, Includes Physician	10% after deductible[5,7]	40% after deductible[5,7]

Active EE/Retiree HDHP Medical Program Cost-Sharing Features, Covered Services, and Limitations	Member's Share of Covered Charges	
DRUG PLAN: Prescription Drugs, Insulin, Diabetic Supplies, Nutritional Products, Specified Vaccines[8]		
Members must use a participating pharmacy. Enteral nutritional products, compounded medications, special medical foods, and other drugs require preauthorization or benefits will be denied.	**Generic Drug**	**Brand-Name Drug[8]** (Generic is available and/or Generic is not available)
Retail Pharmacy Program (up to a 30-day supply or 180 units, whichever is less) benefits include Flu, Pneumococcal, and Zostavax vaccines, for which ***no copayment*** is required.	You pay 20% of covered charges after deductible	
Mail-Order Service (up to a 60-or 90-day supply or 540 units, whichever is less)		
Nonprescription enteral nutritional products and special medical foods (up to a 30-day supply pre 30-day period; requires preauthorization	You pay 20% of covered charges after deductible	

FOOTNOTES:

1 All services are subject to deductible. When applicable, the deductible must be met before benefit payments are made.

2 After you reach an out-of-pocket limit, the Plan pays 100 percent of most of your covered Preferred Provider (In-Network) or Nonpreferred Provider (Out-of-Network) charges, whichever is applicable, for the rest of the calendar year. Items covered under the drug plan are subject to the Preferred Provider (In-Network) out-of-pocket limit. Preferred Provider (In-Network) expenses do **not** cross-apply to the Nonpreferred Provider (Out-of-Network) limit or vice versa.

3 Initial treatment of a medical emergency is paid at the Preferred Provider (In-Network) benefit level. Follow-up treatment and treatment that is not for an emergency and received from an out-of-network provider is paid at the Nonpreferred Provider (Out-of-Network) level.

4 Certain services are **not covered** if preauthorization is not obtained from BCBSNM (or the BCBSNM Behavioral Health Unit). A list of services requiring preauthorization and a description of when obtaining preauthorization is **your** responsibility is in Section 4. Some services may require a written request for preauthorization in order to be covered. (Nonemergency ambulance services are covered **only** when it is medically necessary to transfer the patient from one facility to another.)

5 Preauthorization is required for inpatient admissions. You pay a **$300 penalty** for covered inpatient facility services if preauthorization is your responsibility and is not obtained.

6 Rental benefits for medical equipment and other items will not exceed purchase price of a new unit.

7 LANS has authorized the Claims Administrator to approve, when used as a cost-effective alternative to inpatient hospitalization, residential treatment center services for patients being treated for chemical dependency and mental health.

8 Prescription drugs must be purchased at a pharmacy that participates in the Retail Pharmacy/Specialty Pharmacy Drug or Mail-Order Service Programs. (BCBSNM has contracted with a separate program for administration of your prescription drug benefits.) If you require a brand-name drug for which there is a generic equivalent, you will pay the difference in cost between the brand-name drug and the generic drug, plus the deductible (if not met) and the 20 percent coinsurance amount.

NOTE: Deductibles, copayments, and coinsurance percentages are applied to BCBSNM's covered charges, which may be less than the provider's billed charges. Preferred Providers will not charge you the difference between the covered charge and the billed charge for covered services; Nonpreferred Providers may.

NOTE: BCBSNM provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims, except as may be specified in the Administrative Services Agreement.